



Notification From Medical Provider of COVID-19 Laboratory Results



MEDICAL PROVIDER INFORMATION

| | | | |
|---|----------------|----------------|--|
| Physician/Infection Preventionist Name | | Facility Name | |
| Physician/ Infection Preventionist Pager/Phone number | E-mail Address | Date of Report | |

PATIENT INFORMATION

| | | | | | | |
|--|--------------------------|--|---------------|---------------|----------|-----|
| Patient Name-Last, First, Middle Initial | | Facility name (if not living at home): | | Date of Birth | Age | Sex |
| Address- Number, Street, Apt # | | City | | State | ZIP Code | |
| Primary Phone Number | Alternative Phone Number | | Email Address | | | |

Patient currently resides in: ☐ Private residence ☐ Hotel ☐ Homeless ☐ Detention facility ☐ Nursing home/long-term healthcare
☐ Residential Care/Assisted Living ☐ School/University dorm ☐ Military base ☐ Shelter ☐ Other: _____

Occupation: ☐ Healthcare Worker ☐ Teacher ☐ EMT ☐ Other: _____

CLINICAL INFORMATION

| | | | |
|---------------|---|-------------------|-----------------------|
| Date of onset | Hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No | Date of admission | Medical Record Number |
|---------------|---|-------------------|-----------------------|

Does the patient have the following signs and symptoms (check all that apply)?

| | | | | |
|--|--|---|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Muscle aches | <input type="checkbox"/> Sore throat | <input type="checkbox"/> Subjective Fever | <input type="checkbox"/> Abdominal pain |
| <input type="checkbox"/> Cough | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Chills | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Other, Specify: _____ |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Fever ¹ (>100.4F or 38C) | <input type="checkbox"/> Vomiting or nausea | <input type="checkbox"/> Headache | <input type="checkbox"/> Unknown |

Severe Acute Lower Respiratory Illness: (☐ pneumonia **OR** ☐ ARDS): Chest x-ray/CT results: _____

Pre-existing medical conditions (check all that apply):

| | | | | | | |
|---------------------------------------|--|--|--|--|---|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Unknown | <input type="checkbox"/> Pregnancy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Cardiovascular disease | <input type="checkbox"/> Chronic pulmonary disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic renal disease | <input type="checkbox"/> Chronic liver disease | <input type="checkbox"/> Immunocompromised | <input type="checkbox"/> Neurologic disability | | |
| <input type="checkbox"/> Other: _____ | | | | | | |

LABORATORY INFORMATION

| | | |
|------------------------|---------------------------|---------------|
| Nasal pharyngeal swab: | Date of Collection: _____ | Result: _____ |
| Oropharyngeal swab: | Date of Collection: _____ | Result: _____ |

EPIDEMIOLOGY RISK FACTORS

☐ Close contact* with a laboratory-confirmed COVID-19 patient

* Close contact is defined as: a) being within approximately 6 feet (2 meters) or within the room or care area for a prolonged period of time (e.g., healthcare personnel, household members) while not wearing recommended personal protective equipment (i.e., gowns, gloves, respirator, eye protection); or b) having direct contact with infectious secretions (e.g., being coughed on) while not wearing recommended personal protective equipment. Data to inform the definition of close contact are limited. At this time, brief interactions, such as walking by a person, are considered low risk and do not constitute close contact.

☐ Travel history to affected geographic areas: (City/Region/Province/State/Country): _____

See current list: <https://www.cdc.gov/coronavirus/2019-ncov/hcp/clinical-criteria.html>

Dates of Travel: To: _____ From: _____ Arrived in U.S.: _____

☐ No known identifiable source

Send this completed form to the Communicable Disease Control Program within 24 hours of receiving positive results: Fax to 562.570.4374 or Secure Email to LBEpi@longbeach.gov